Washington State

Children's Administration

Annual Child Fatality Report

2003

Department of Social and Health Services
Children's Administration
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EXECUTIVE SUMMARY

In calendar year 2003, Washington State experienced the deaths of 769 children under the age of 18. Of these 769 deaths, 162 were reported to the Children's Administration (CA). Fatalities are reported to CA when there are allegations or concerns about abuse and neglect, or for general notification purposes. The following 2003 Child Fatality Report is a compilation of information gathered regarding the deaths reported to CA. The analysis of this information is vital to the work of CA in order to assist CA staff, providers, and community partners in improving the outcomes for the children and families we serve.

The fatalities reported to CA are subdivided into two categories—1) those with CA history within 12 months prior to death and 2) those without history within 12 months. The second category includes both those with history beyond 12 months and those with no CA history. In both of these groups we look at the manner of death along with age, gender, and race. Through analysis of this data, we hope to identify those children most at risk in order to inform and support a system that can improve the protection of children and reduce child fatalities related to abuse and neglect.

Revised Code of Washington (RCW) 74.13.640 requires Child Fatality Reviews on unexpected child deaths, when the family has history with CA within the last 12 months, has an open case at the time of death, or the child was residing in a licensed facility at the time of death. Of the 162 child fatalities reported to CA, 90 met the criteria for a full review. This information is used to identify needed improvements within the system and to recognize quality practice in service delivery to children and families.

INTRODUCTION

Child fatalities in the State of Washington are reviewed by two state agencies. These agencies, the Department of Health (DOH) and the Department of Social and Health Services (DSHS), Children's Administration (CA), have worked together to review child deaths since 1998. DOH collects data on each child death in Washington in order to identify statewide trends and prevention strategies. While DOH has records of all child deaths, CA reviews the death of a child (RCW 74.13.640) when the death is unexpected and the child has history with the Department within the last 12 months, has an open case at the time of death, or the child was residing or receiving services in a licensed facility at the time of death.

Fatalities are reported to CA when there are allegations or concerns about abuse or neglect, or for general notification purposes. Child Fatality Reviews examine all information provided to the Department regarding the children and their families, including history and case activity. The goal of the Child Fatality Review is to increase our understanding of the circumstances surrounding a child's death in order to evaluate practice, CA programs, and the systems involved with the child, to improve the health and safety of children. From this review, areas needing improvement are identified and a work plan is developed to address any identified deficits in practice, policy, or system.

CA's child fatality information is collected via several sources. These include CA's client database, Case and Management Information System (CAMIS), as well as the Administrative Incident Reporting System (AIRS), death certificates, and the regional Child Protective Services (CPS) Program Managers.

AIRS is a relatively new system for CA and usage began in 2002 in pilot sites in Region 2 (Yakima and the surrounding areas) and Region 5 (Pierce/Kitsap County area). All regions were instructed to use this system for fatality reports during 2003. After successful results, AIRS was fully implemented statewide on January 1, 2005. This system was designed to track child fatalities, near fatalities, and other critical incidents and has eliminated the need for several different reporting formats. Information from AIRS is used to identify incident patterns, trends, and systems issues to determine what interventions are needed to improve the health, safety, and well-being of the children and families in Washington State.

In 2003, the State of Washington had 769 child fatalities with 162 (22 percent) reported to CA.[1] Of these, 90 (56 percent) fatalities met the requirements for a Child Fatality Review under CA policy. Seventy-two (44 percent) fatalities had no history with CA or had history beyond 12 months and, therefore, did not require a review, but were reported in the AIRS system. Statistical information on age, race, and gender regarding both sets of fatalities are included in this report.

[1] Data included in the tables and charts presented are based upon reports as of January, 2006 and may change as new reports become available.

Manner and Cause of Death Definitions

Definitions of manner of death and cause of death are essential in the discussion of child fatalities. Manner of death is categorized into the following groups: natural, accident, suicide, homicide, and undetermined. Manner of death does not indicate cause and effect, but is used in conjunction with the cause of death to better describe how the death occurred.[2] The manner of death category is identified by the local medical examiners and coroners.

"Cause of death is the disease or injury" that was responsible for the death or the death events as defined by the American Family Physician. Examples of cause of death include cancer, pneumonia, blunt trauma, Sudden Infant Death Syndrome (SIDS), and poisoning.

The cause of death describes what physically caused the death while manner of death refers to the intention that led to the death. For example, when a person dies from a cocaine overdose, the manner of death could be listed as an accident and the cause of death listed as an overdose of cocaine. In this case, even though the person was engaging in a dangerous activity, it is classified as an accident because the person did not intend to harm himself or herself.

[2] American Family Physician, October 1, 1997, Volume 56, Number 5.

TOTAL 2003 CHILD FATALITIES REPORTED TO CA

In 2003, 162 child fatalities were reported to CA. This includes those with and without previous involvement with CA. Table 1 and Figure 1 display how the manner of death for these children was classified.

Total 2003 Child Fatalities by Manner of Death		
Accident	41	25%
Homicide by Abuse	12	7
Homicide by Third Party	11	7
Natural-Medical	58	36
Suicide	10	6
Unknown-Undetermined	30	19
Total	**162**	**100%**

Table 1

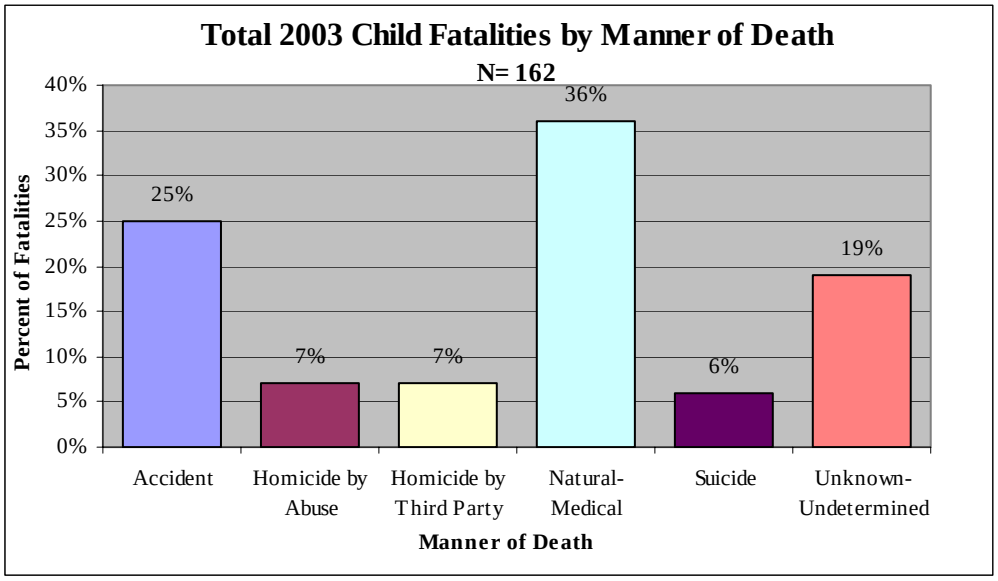

Figure 1

Table 2 displays the number of referrals regarding the child prior to the fatality. Sixty-four or 40 percent of the 162 fatalities did not have any referrals prior to the fatality.

Number of Referrals Prior to Fatality		
None	64	40%
One	35	22
Two	16	10
Three	12	7
Four to Five	13	8
Six to Ten	10	6
> Ten	12	7
Total	**162**	**100%**

Table 2

Total 2003 Child Fatalities Reported To CA - Race

A comparison of racial groups as they relate to child fatalities can be beneficial. See Table 3 and Figure 2.

Total 2003 Child Fatalities by Race		
African American	16	10%
Asian	7	4
Caucasian	83	51
Hispanic	18	11
Native American	19	12
Other	19	12
Total	**162**	**100%**

Table 3

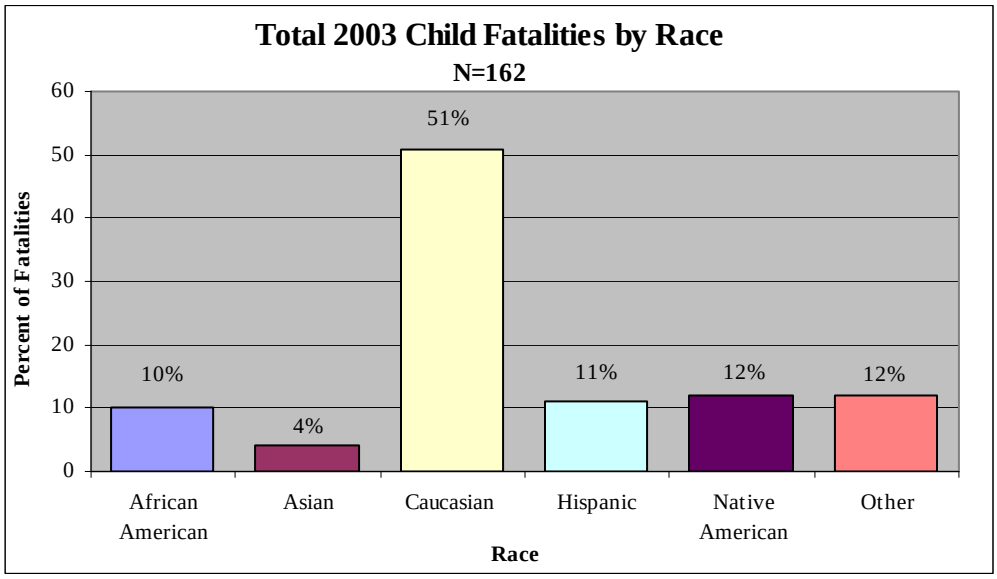

Figure 2

Total 2003 Child Fatalities Reported To CA - Age and Gender

Child fatalities are divided into the following age groups, under (<) 1 year, 1 to 3 years, 4 to 6 years, 7 to 12 years, and 13 to 18 years. See Table 4 and Figure 3. As is illustrated in the data, fatalities occur more frequently between 0 to 3 years of age than in any other age group with 57 percent of all fatalities reported to CA occurring during this preverbal stage.

Total 2003 Child Fatalities Reported to CA by Age and Gender						
Age	**Males**	**% of Males by Gender**	**Females**	**% of Females by Gender**	**Age Totals**	**% by Age**
< 1 Year	38	40%	36	54%	74	47%
1-3 Years	12	13	5	8	17	10
4-6 Years	7	7	5	8	12	7
7-12 Years	8	8	12	18	20	12
13-17 Years	31	32	8	12	39	24
Totals	**96**	**100%**	**66**	**100%**	**162**	**100%**

Table 4

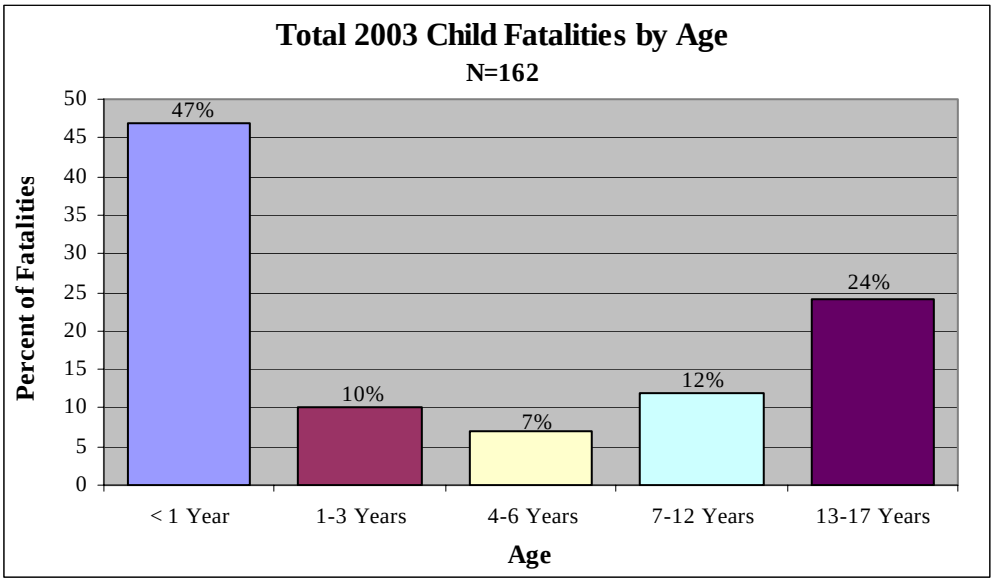

Figure 3

For children ages 13 to17, 10 (26 percent) of the 39 deaths were suicides (8 male, 2 female). Of these ten children, six were Caucasian, two were Native American, one was Hispanic, and one was Caucasian/African American. In review of the history of these children, nine out of the ten suicides had prior history with CA—five within 12 months and four beyond 12 months. Four cases previously had Family Reconciliation Services (FRS) and five cases had CPS history.

As illustrated in Figure 4, there are differences between the genders in regard to the age at which the majority of fatalities occurred. The majority of female deaths (54 percent) occurred prior to age one. Seventy-two percent of male deaths were distributed between the less than one age group and the 13 to 17 year-old age group, 40 percent and 32 percent respectively.

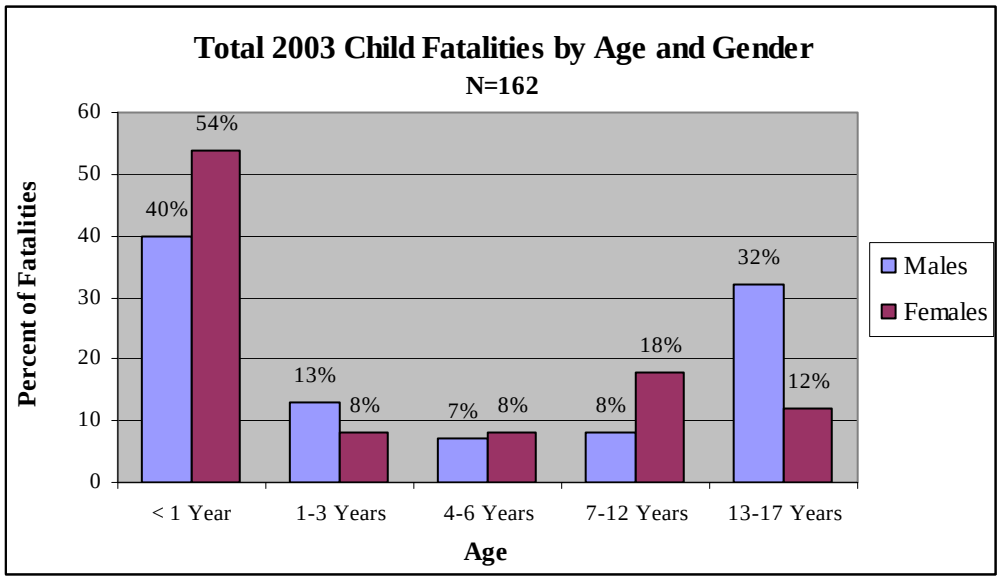

Figure 4

CHILD FATALITIES WITH NO CA HISTORY WITHIN 12 MONTHS OF DEATH

Of the 162 child fatalities reported to CA, 72 were identified as not having CA history and, as such, were not required to have reviews. The majority of these cases were found to be accidental, natural, and unknown. See Table 5 and Figure 5.

Child Fatalities with No CA History within 12 Months Prior to Death		
Accident	20	29%
Homicide by Abuse	6	8
Homicide by Third Party	3	4
Natural-Medical	19	26
Suicide	5	7
Unknown-Undetermined	19	26
Total	**72**	**100%**

Table 5

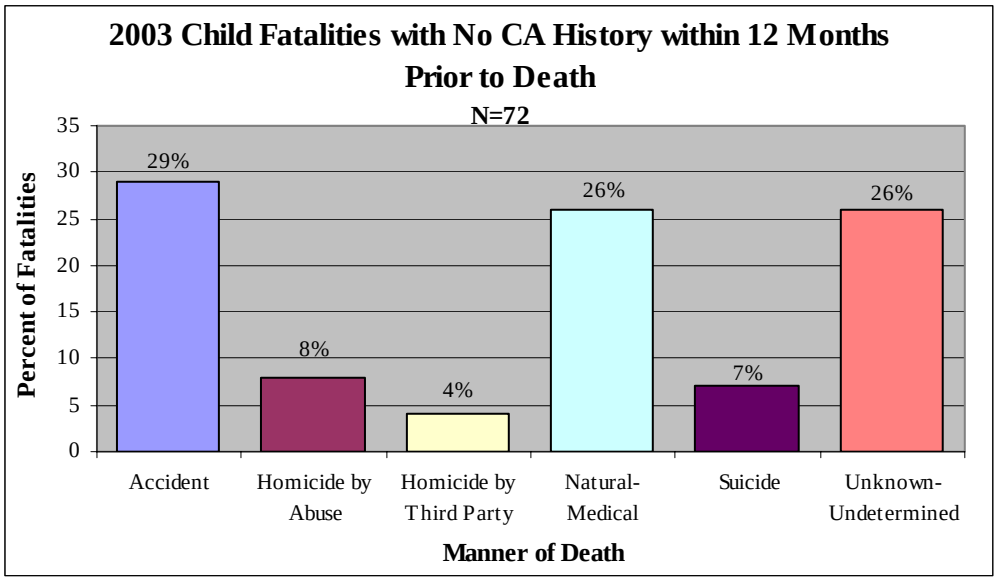

Figure 5

Child Fatalities with No History within 12 Months of Death – Race

Child fatalities without previous CA history follow a similar trend as children who have had history with CA. See Table 6 and Figure 6. It should be noted that in a high percentage (25 percent) of these deaths, race is other/unknown.

2003 Child Fatalities with No CA History within 12 Months Prior to Death by Race		
African American	9	13%
Asian	3	4
Caucasian	28	39
Hispanic	8	11
Native American	6	8
Other	18	25
Total	**72**	**100%**

Table 6

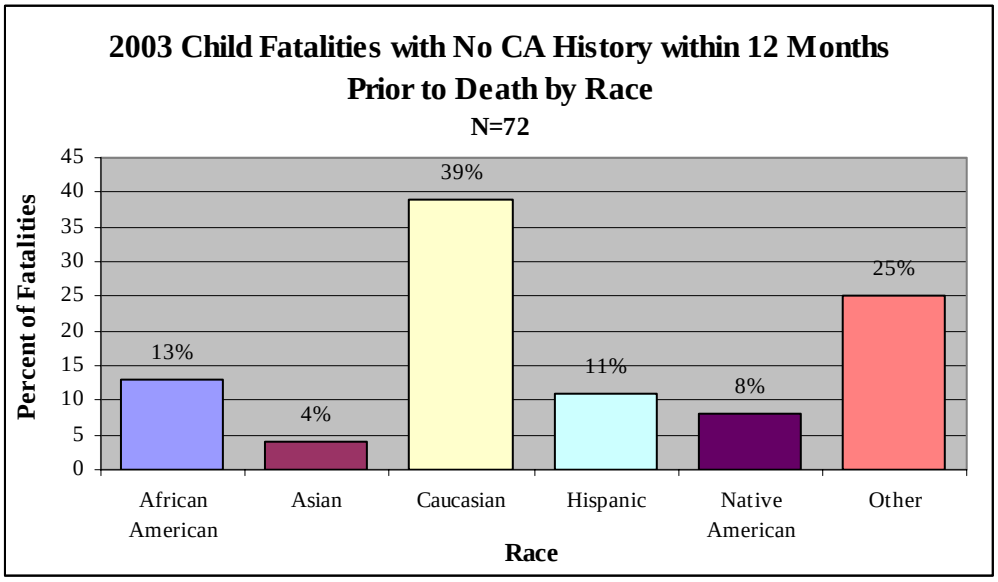

Figure 6

Child Fatalities with No History within 12 Months of Death - Age and Gender

As with race, the gender and age distribution of fatalities is similar between those with prior history and those without. See Table 7 and Figure 7.

2003 Child Fatalities with No CA History within 12 Months Prior to Death by Age and Gender						
Age	**Males**	**% of Males by Gender**	**Females**	**% of Females by Gender**	**Age Totals**	**% by Age**
< 1 Year	17	36%	15	60%	32	44%
1-3 Years	9	19	1	4	10	14
4-6 Years	4	9	2	8	6	8
7-12 Years	7	15	5	20	12	17
13-17 Years	10	21	2	8	12	17
Totals	**47**	**100%**	**25**	**100%**	**72**	**100%**

Table 7

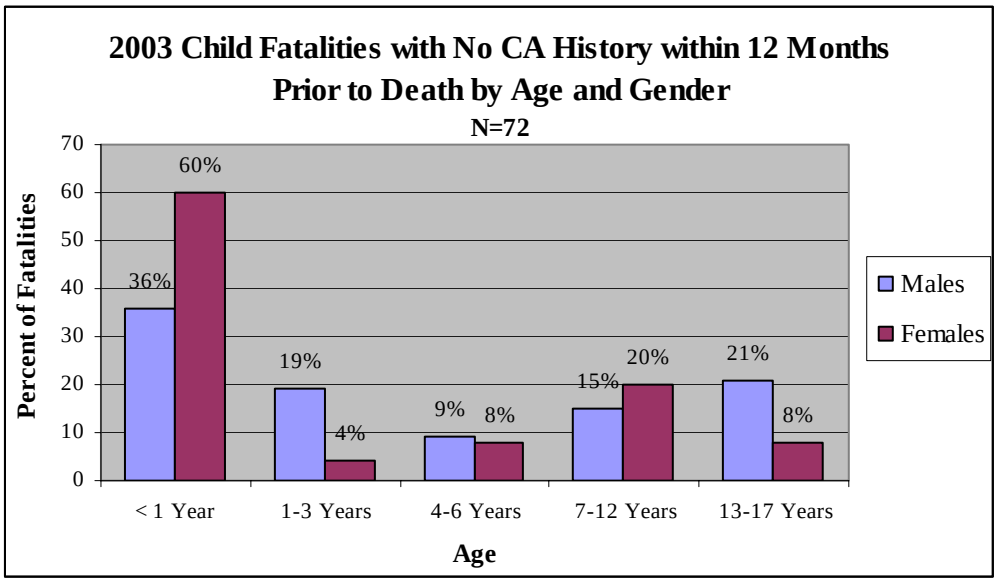

Figure 7

CHILD FATALITY WITH CA HISTORY WITHIN 12 MONTHS OF DEATH

In 2003, 90 fatalities required review either due to history with CA within the 12 months prior to the fatality or as a result of the death occurring in a licensed facility. See Table 8 and Figure 8 for the manner of death for these fatalities.

Six children's deaths were due to homicide by abuse with CA history within 12 months prior to death. The six child deaths were due to the following reasons: three by Shaken Baby Syndrome, two by physical assault, and one by strangulation. The ages for these six children were:

- 20 months
- 24 months
- 30 months
- 9 months
- 7 months
- 17 years

The ages are reflective of the high incidence of child fatalities among the younger age population. The average age is four years, but this is not representative of the group due to the death of the 17 year-old. If you remove the 17 year-old from the equation, the average age is 18 months.

2003 Child Fatalities with CA History by Manner of Death		
Accident	21	23%
Homicide by Abuse	6	7
Homicide by Third Party	8	9
Natural-Medical	39	43
Suicide	5	6
Unknown-Undetermined	11	12
Total	**90**	**100%**

Table 8

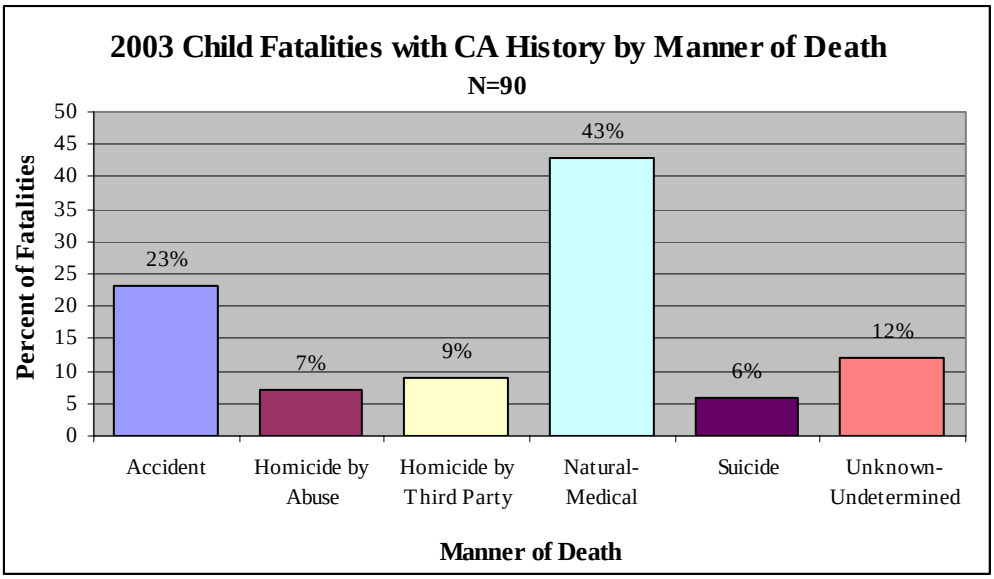

Figure 8

Child Fatality with CA History within 12 Months of Death - Race

See Table 9 and Figure 9.

2003 Child Fatalities with CA History by Race		
African American	7	8%
Asian	4	4
Caucasian	55	62
Hispanic	10	11
Native American	13	14
Other	1	1
Total	**90**	**100%**

Table 9

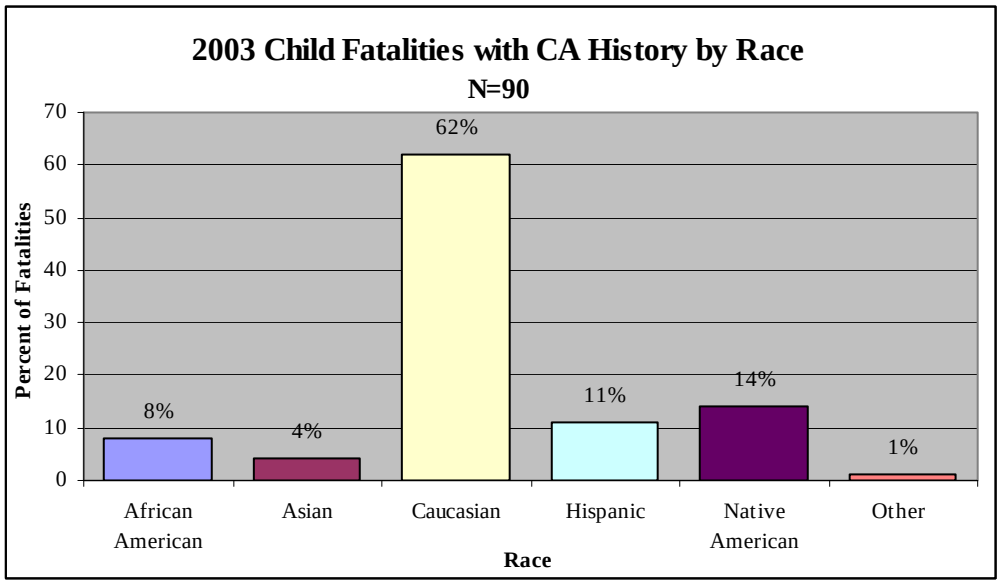

Figure 9

Child Fatality with CA History within 12 Months of Death - Age and Gender

Female child fatalities accounted for 45 percent of those fatalities that had prior history with CA while males accounted for 55 percent. It should be noted that 42 fatalities (46 percent) were infants and 27 fatalities (30 percent) were in the 13 to17 year-old age group. See Table 10 and Figure 10.

2003 Child Fatalities with CA History by Age and Gender						
Age	**Males**	**% of Males by Gender**	**Females**	**% of Females by Gender**	**Age Totals**	**% by Age**
< 1 Year	21	43%	21	51%	42	46%
1-3 Years	3	6	4	10	7	8
4-6 Years	3	6	3	7	6	7
7-12 Years	1	2	7	17	8	9
13-17 Years	21	43	6	15	27	30
Totals	**49**	**100%**	**41**	**100%**	**90**	**100%**

Table 10

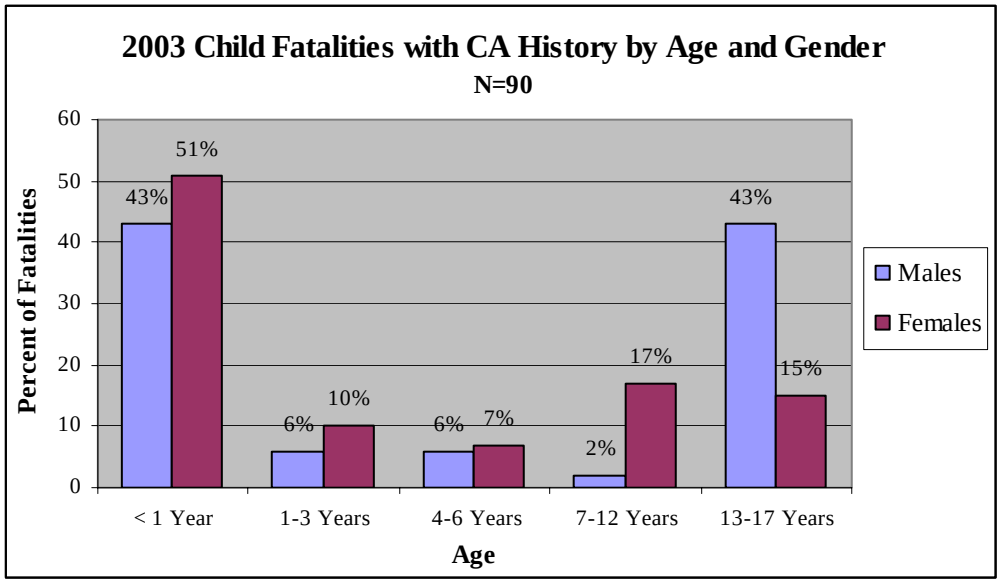

Figure 10

REFERENCES

Broderick, Susan, J.D. Reducing Child Fatalities Through a Team Approach, American Prosecutors Research Institute, Volume 17, Number 8, 2004.

Davis, GG. Mind your Manners Part 1: History of Death Certification and Manner of Death Classification, Am J. Forensic Med Pathol 1997; 18(3):219-223.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Robert J. Mills. U.S. Census Bureau, Current Population Reports, P60-226, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, U.S. Government Printing Office, Washington, DC, 2004.

Hanzlick, M.D., Randy, John Hunsaker III, MD, JD, Gregory David, MD. A Guide for Manner of Death Classification, National Association of Medical Examiners, February 2002.

Magrane, M.D., Brian P., MGF Gilliland, M.D., and Dana E. King, M.D. Certification of Death by Family Physicians, American Family Physician, October 1, 1997, Volume 56, Number 5.

U.S. Census Bureau Public Information Office, U.S. Census 2000, February, 2005.